

**Core Participant *Intake* Form
Children Under 3**

Program name:

Date:

Child's <u>first</u> name as it appears on birth certificate:		Child's <u>middle</u> name: <i>(optional)</i>	
Child's current <u>last</u> name:		Mother's <u>maiden</u> name (if applicable): <i>(optional)</i>	
Mother's <u>first</u> name:	Child's date of birth: mm / dd / yyyy	Child's gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Place of Birth: <input type="checkbox"/> If born in California, specify <u>county</u> : _____ <input type="checkbox"/> If born in other U.S. state, specify <u>state</u> : _____ <input type="checkbox"/> If born in other country, specify <u>country</u> : _____			Note: if client declines to specify place of birth, you may note as "unknown" under any category
Street Address: <i>(optional)</i>		City, State: <i>(optional)</i>	
Zip code:	Phone number: <i>(optional)</i> ()	Consent date: mm / dd / yyyy	
Date of first service: mm / dd / yyyy	Add to service group(s)? <i>(optional)</i> If yes, specify:		
Ethnicity (check <i>all</i> that apply): <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> Alaska Native or American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian </div> <div style="width: 30%;"> <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Mexican, Mexican-American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central American <input type="checkbox"/> Other Hispanic/Latino </div> <div style="width: 30%;"> <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other: specify _____ <input type="checkbox"/> Unknown </div> </div>			
What language does the family speak most often at home? <i>(check ONE box)</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Mostly English <input type="checkbox"/> English and another language equally (indicate other language below) </div> <div style="width: 45%;"> <input type="checkbox"/> Mostly another language (indicate other language below) <input type="checkbox"/> Unknown </div> </div>			
If language other than English, which language? <i>(check ONE box)</i> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 20%;"> <input type="checkbox"/> Cantonese <input type="checkbox"/> Hmong <input type="checkbox"/> Korean <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog (Pilipino) <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <i>(continue with longer list below)</i> <input type="checkbox"/> Albanian <input type="checkbox"/> Amharic (Ethiopian) </div> <div style="width: 20%;"> <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Assyrian <input type="checkbox"/> Bosnian <input type="checkbox"/> Burmese <input type="checkbox"/> Cebuano (Visayan) <input type="checkbox"/> Chaldean <input type="checkbox"/> Chamorro (Guamanian) <input type="checkbox"/> Chaozhou (Chaochow) <input type="checkbox"/> Croatian <input type="checkbox"/> Dutch <input type="checkbox"/> Farsi (Persian) <input type="checkbox"/> French </div> <div style="width: 20%;"> <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Gujarati <input type="checkbox"/> Hebrew <input type="checkbox"/> Hindi <input type="checkbox"/> Hungarian <input type="checkbox"/> Ilocano <input type="checkbox"/> Indonesian <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Khmer (Cambodian) <input type="checkbox"/> Khmu <input type="checkbox"/> Kurdish <input type="checkbox"/> Lahu </div> <div style="width: 20%;"> <input type="checkbox"/> Lao <input type="checkbox"/> Mandarin (Putonghua) <input type="checkbox"/> Marshallese <input type="checkbox"/> Mien <input type="checkbox"/> Mixteco <input type="checkbox"/> Pashto <input type="checkbox"/> Polish <input type="checkbox"/> Portuguese <input type="checkbox"/> Punjabi <input type="checkbox"/> Rumanian <input type="checkbox"/> Russian <input type="checkbox"/> Samoan <input type="checkbox"/> Serbo-Croatian <input type="checkbox"/> Somali </div> <div style="width: 20%;"> <input type="checkbox"/> Swahili <input type="checkbox"/> Taiwanese <input type="checkbox"/> Thai <input type="checkbox"/> Tigrinya <input type="checkbox"/> Toishanese <input type="checkbox"/> Tongan <input type="checkbox"/> Turkish <input type="checkbox"/> Ukrainian <input type="checkbox"/> Urdu <input type="checkbox"/> Other language, specify: _____ <input type="checkbox"/> Unknown </div> </div>			

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Please mark (X) as indicated for each question.

<p>1. How much did your child weigh when he/she was born?</p>		<p><i>Pounds</i></p>	<p><i>Kilogram s</i></p>	<p><i>Grams</i></p>
	<input type="checkbox"/>	3 lbs. 4 oz. and below	Under 1.5	Under 1500
	<input type="checkbox"/>	3 lbs. 5 oz. - 5 lbs. 7 oz.	1.5 – 2.4	1500 - 2499
	<input type="checkbox"/>	5 lbs. 8 oz. - 7 lbs. 15 oz.	2.5 – 3.5	2500 - 3599
	<input type="checkbox"/>	8 lbs. or more	3.6 or more	3600 or more
<input type="checkbox"/> <i>Don't know/Declined</i>				
<p>2a. (Ask only <i>mother</i>): How many months pregnant were you when you first received prenatal care (saw a doctor) for this pregnancy?</p>	<p>____ <i>Number of months</i></p> <p><input type="checkbox"/> <i>Did not see a doctor during the pregnancy</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			
<p>2b. (Ask only <i>mother</i>): During your pregnancy, how many times did you see your doctor for prenatal care?</p>	<p><input type="checkbox"/> <i>Never</i></p> <p><input type="checkbox"/> <i>1 time</i></p> <p><input type="checkbox"/> <i>2 times</i></p> <p><input type="checkbox"/> <i>3 times</i></p> <p><input type="checkbox"/> <i>4 times</i></p> <p><input type="checkbox"/> <i>5 times</i></p> <p><input type="checkbox"/> <i>6 times</i></p> <p><input type="checkbox"/> <i>7 or more times</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			
<p>2c. (Ask only <i>mother</i>): Was your child born more than two weeks before he/she was due?</p>	<p><input type="checkbox"/> <i>Yes</i></p> <p><input type="checkbox"/> <i>No → Skip question 2d</i></p> <p><input type="checkbox"/> <i>Don't know/Declined → Skip question 2d</i></p>			
<p>2d. (Ask only <i>mother</i>): How many days or weeks early was he/she?</p>	<p><i>Enter number:</i> ____ ____</p> <p><input type="checkbox"/> <i>Weeks</i></p> <p><i>or</i></p> <p><input type="checkbox"/> <i>Days</i></p>			
<p>3. (Ask only <i>mother</i>): How old were you when your child was born?</p>	<p>____ ____ <i>Years of age</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			
<p>4. (Ask only <i>mother</i>): Since your child was born, has a doctor or other professional asked you questions about how often you felt depressed or hopeless?</p>	<p><input type="checkbox"/> <i>Yes</i></p> <p><input type="checkbox"/> <i>No</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			
<p>5a. (Ask only <i>mother</i>): Did you breastfeed your child?</p>	<p><input type="checkbox"/> <i>Yes</i></p> <p><input type="checkbox"/> <i>No → Skip question 5b</i></p> <p><input type="checkbox"/> <i>Don't know/Declined → Skip question 5b</i></p>			
<p>5b. (Ask only <i>mother</i>): How old was your child when breastfeeding ended?</p>	<p>____ . ____ <i>Number of months when ended</i></p> <p><input type="checkbox"/> <i>Still breast feeding</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			
<p>6. (Ask only <i>mother</i>): Did you smoke at any time while you were pregnant with him/her?</p>	<p><input type="checkbox"/> <i>Yes</i></p> <p><input type="checkbox"/> <i>No</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>			

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7.	Does your child have any kind of health insurance now, such as insurance through an HMO, a private insurance company, Medi-Cal, Healthy Families, or something else?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
7b.	What type of primary health insurance is the child currently covered by?	<input type="checkbox"/> Uninsured <input type="checkbox"/> Insurance purchased directly by parent/guardian <input type="checkbox"/> Employer-purchased health insurance <input type="checkbox"/> Military Health Care /CHAMPUS/VA <input type="checkbox"/> Medi-Cal (full scope/comprehensive) <input type="checkbox"/> Medi-Cal (emergency) <input type="checkbox"/> Healthy Families <input type="checkbox"/> Healthy Kids/California Kids/ or similar program <input type="checkbox"/> California Children's Services (CCS) <input type="checkbox"/> Child Health and Disability Prevention Program <input type="checkbox"/> Access for Infants and Mothers (AIM) <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other <input type="checkbox"/> <i>Don't know/Declined</i>
8a.	Is there a place, other than an emergency room, where your child usually goes when he/she is sick or you need advice about his/her health?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
8b.	Is there a doctor or other health care provider that you usually take your child to for well-child care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
9.	How many times in the last year did your child receive a well-child checkup, that is, a general checkup when he/she was not sick or injured?	<input type="checkbox"/> 0 visits <input type="checkbox"/> 1 visit <input type="checkbox"/> 2 visits <input type="checkbox"/> 3 visits <input type="checkbox"/> 4 visits <input type="checkbox"/> 5 visits <input type="checkbox"/> 6 or more visits <input type="checkbox"/> <i>Don't know/Declined</i>
10a.	Did your child's doctor or health care provider ever tell you that they were doing a "developmental assessment" of him/her?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
10b.	Did your child's doctor or health care provider ever have him/her pick up small objects or stack blocks or throw a ball or recognize different colors?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
11a.	Has a doctor or other health, school district, or regional center professional ever told you that your child was developmentally delayed? A developmental delay means the child is somewhat slower physically or mentally than other children the same age.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>

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11b. Has a doctor or other health, school district, or regional center professional ever told you that your child has any of the other following disabilities or special needs? (<i>Check all that apply.</i>)	<input type="checkbox"/> Mental retardation <input type="checkbox"/> At risk <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Deafness <input type="checkbox"/> Visual impairment (including blindness) <input type="checkbox"/> Deaf-blindness <input type="checkbox"/> Speech or language impairment <input type="checkbox"/> Emotional disturbance <input type="checkbox"/> Autism <input type="checkbox"/> Specific learning disability <input type="checkbox"/> Orthopedic impairment <input type="checkbox"/> Other health impairment <input type="checkbox"/> Multiple disabilities <input type="checkbox"/> No <input type="checkbox"/> Don't know/Declined				
11c. Does your child currently have or has your child ever had an Individualized Family Service Plan (sometimes called an "IFSP") or an Individualized Education Plan (sometimes called an "IEP")?	<input type="checkbox"/> Yes— <i>Currently</i> <input type="checkbox"/> Yes— <i>In the past, but not currently</i> <input type="checkbox"/> No <input type="checkbox"/> Don't know/Declined				
11d. Sometimes parents have concerns about their children. Are you concerned <i>a lot</i> , <i>a little</i> , or <i>not at all</i> about ¹ :	<i>A lot</i>	<i>A little</i>	<i>Not at all</i>	<i>N/A</i>	<i>Don't Know/Decline</i>
a) How your child talks or makes speech sounds?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) How your child sees?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) How your child hears?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) How your child understands what you say?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) How your child uses his or her hands and fingers to do things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) How your child uses his or her arms and legs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) How your child is learning preschool or school skills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) How your child gets along with others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) How your child behaves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) How your child is learning to do things for himself or herself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Whether your child can do what other children his or her age can do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Your child's emotional well-being?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13a. How much does your child weigh now (<i>without shoes</i>)?	<div style="display: flex; align-items: center; justify-content: center;"> <div style="border-bottom: 1px solid black; width: 100px; margin-right: 5px;"></div> <div style="margin-right: 5px;">.</div> <div style="border-bottom: 1px solid black; width: 50px; margin-right: 5px;"></div> <div style="margin-right: 5px;">Pounds or</div> <div style="margin-right: 5px;"><input type="checkbox"/></div> <div style="margin-right: 5px;">Kilograms</div> <div style="margin-right: 5px;"><input type="checkbox"/></div> </div> <div style="margin-top: 5px;"><input type="checkbox"/> Don't know/Declined</div>				

¹ Note: The items in question 11d. are drawn from the survey edition of Parents' Evaluation of Developmental Status (PEDS) and do not have an immediate clinical application. Users interested in early detection will need to purchase the actual test (www.pedstest.com). The survey version items are copyrighted and may not be used without express permission from the author (Frances.P.Glascoe@Vanderbilt.edu).

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13b. How tall is your child now?	____ Feet or ____ ____ Inches ____ ____ ____ Centimeters <input type="checkbox"/> <i>Don't know/Declined</i>
15. Does your child have dental insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
16. When did your child last see a dentist or dental hygienist for dental care?	<input type="checkbox"/> <i>Child under 12 months of age</i> <input type="checkbox"/> Less than a year ago <input type="checkbox"/> 1 year ago, but less than 2 years ago <input type="checkbox"/> 2 years ago or more <input type="checkbox"/> Never <input type="checkbox"/> <i>Don't know/Declined</i>
19a. In a typical week, how often do you or any other family member sing songs with your child?	<input type="checkbox"/> <i>Child under 12 months of age</i> <input type="checkbox"/> Not at all <input type="checkbox"/> Once or twice a week <input type="checkbox"/> 3-6 times a week <input type="checkbox"/> Every day <input type="checkbox"/> <i>Don't know/Declined</i>
19b. In a typical week, how often do you or any other family member read to or show picture books to your child?	<input type="checkbox"/> <i>Child under 12 months of age</i> <input type="checkbox"/> Not at all <input type="checkbox"/> Once or twice a week <input type="checkbox"/> 3-6 times a week <input type="checkbox"/> Every day <input type="checkbox"/> <i>Don't know/Declined</i>
19c. In a typical week, how often do you or any other family member tell stories to your child?	<input type="checkbox"/> <i>Child under 12 months of age</i> <input type="checkbox"/> Not at all <input type="checkbox"/> Once or twice a week <input type="checkbox"/> 3-6 times a week <input type="checkbox"/> Every day <input type="checkbox"/> <i>Don't know/Declined</i>
20. Does anyone in your household smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>
21. How many times have you and your family moved in the last 12 months?	____ Number of times <input type="checkbox"/> <i>Don't know/Declined</i>
22. Which of these statements about food best describes your household in the last 6 months?	<input type="checkbox"/> We have enough to eat and the kinds of food we want. <input type="checkbox"/> We have enough to eat but not always the kinds of food we want. <input type="checkbox"/> Sometimes we don't have enough to eat. <input type="checkbox"/> Often we don't have enough to eat. <input type="checkbox"/> <i>Don't know/Declined</i>
23. Do you/does the child's mother have a high school diploma or a GED?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Don't know/Declined</i>

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<p>24a. How many family members are there in the household, including you?</p>	<p>_____ <i>Number of family members in household</i></p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>
<p>24b. Can you tell me about how much money (income) your family received in the last 12 months? Include money from any source you can think of.</p>	<p>\$_____</p> <p><input type="checkbox"/> <i>Don't know/Declined → Ask 24c.</i></p>
<p>24c. We don't need to know exactly, but which of the following categories best describes your total family income in the last 12 months?</p>	<p><input type="checkbox"/> <i>Don't know/Declined</i></p> <p><input type="checkbox"/> Less than \$10,000</p> <p><input type="checkbox"/> \$10,000 – less than \$20,000</p> <p><input type="checkbox"/> \$20,000 – less than \$30,000</p> <p><input type="checkbox"/> \$30,000 – less than \$40,000</p> <p><input type="checkbox"/> \$40,000 – less than \$50,000</p> <p><input type="checkbox"/> \$50,000 – less than \$75,000</p> <p><input type="checkbox"/> \$75,000 or more</p>
<p>25. Overall, would you say your child's health is...</p>	<p><input type="checkbox"/> Excellent</p> <p><input type="checkbox"/> Very good</p> <p><input type="checkbox"/> Good</p> <p><input type="checkbox"/> Fair, or</p> <p><input type="checkbox"/> Poor</p> <p><input type="checkbox"/> <i>Don't know/Declined</i></p>